Health Department: _____

Address: _____

Phone: _____

I.D. Verification (copy)
Driver's License _____
School I.D. _____
Employment I.D. _____
Professional License _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

REQUESTING PARTY: Today's Date_____

Printed Legal Name_____Date of Birth_____SS #_____
(medical information about)

I, the undersigned, hereby authorize:

Name of Agency_____Location_____
Address_____
City, State, Zip_____

To provide the following information from my medical record or the record of a minor:

_____

_____

Sign next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information	Yes_____	No_____
Mental Health Information	Yes_____	No_____
AIDS/HIV Testing & Results	Yes_____	No_____
Sexually Transmitted Diseases Testing & Results	Yes_____	No_____
Communicable Diseases	Yes_____	No_____

and is limited to the time period from_____to_____

RELEASE TO: ***NOTARIZED:***

Name of agency or person_____
Address_____
City, State, Zip_____

SIGNATURES: *(Consent is valid for 90 days from date signed for closed records)*

Requesting Party_____Date_____
For_____Relationship_____
Witness_____Date_____

_____
Notary Signature
Expiration Date_____

****

FOR OFFICE USE ONLY:

Date request received by _____Date request given or sent_____
Other Information (program/archive info)_____
staff responsible for providing client medical information_____
(legible signature)

June 2000 ed